NEBRASKA AdministrativeServices

GALLAGHER BASSETT
GUIDE. GUARD. GO BEYOND.

Appendix A

EMPLOYEE'S CHOICE OR CHANGE OF DOCTOR FORM

NOTICE TO EMPLOYER:

GIVE THIS FORM TO THE INJURED WORKER AS SOON AS POSSIBLE AFTER EACH INJURY

PART A: NOTICE REGARDING CHOICE OR CHANGE OF DOCTOR

Under the Nebraska workers' compensation laws, you may have the right to choose a doctor to treat you for your work-related injury. You may choose a doctor who has treated you or an immediate family member before this injury happened. Immediate family members are your spouse, children, parents, stepchildren and stepparents. The doctor you choose must have records to show that past treatment was provided. Your employer may ask the person who was treated to give permission so the doctor can verify past treatment.

If you want to choose your doctor, you must tell your employer the name of the doctor you choose. Do this as soon as possible after your employer gives you this notice and before getting any treatment unless it is emergency medical treatment. Once you tell your employer the name of the doctor, you may not change your choice unless your employer agrees or the Nebraska Workers' Compensation Court orders a change.

If you do not choose your doctor, your employer has the right to choose the doctor to treat you. The employer may also choose the doctor to treat you if you or your family member does not give permission so your employer can verify past treatment by the doctor you chose.

You may choose a doctor if your claim is denied. You may also choose the doctor to do major surgery or for an amputation.

You may use Part B (below) to tell your employer the name of the doctor you choose.

☐ My employer has informed me of the above information regarding choice or change of doctor.

[PRINT NAME OF EMPLOYEE]

[SIGNATURE OF EMPLOYEE] [DATE]

PART B: CHOICE OF DOCTOR

☐ I choose the following doctor to treat me for this work-related injury. I certify that this doctor has treated me or an immediate family member before the work-related injury.

☐ I do not have or I do not wish to choose a doctor who has treated me or an immediate family member.

[DOCTOR'S NAME] [SIGNATURE OF EMPLOYEE]

[DOCTOR'S ADDRESS] [DATE]

PART C: USE TO CHANGE THE CHOICE MADE IN PART B, ABOVE

I wish to change my choice of doctor or I wish to choose a doctor to treat me for my work-related injury. I certify the doctor named below has treated me or an immediate family member before this work-related injury. I understand that I cannot make this change unless my employer agrees or unless the Nebraska Workers' Compensation Court orders a change.

[DOCTOR'S NAME] [SIGNATURE OF EMPLOYEE & DATE OF SIGNATURE]

[DOCTOR'S ADDRESS] [SIGNATURE OF EMPLOYER & DATE OF SIGNATURE]

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Appendix B

FIRST SCRIPT®

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Prescription Program For Work-Related Injuries

Welcome to First Script, a pharmacy benefit program designed exclusively for **State of Nebraska, #009006,** in partnership with Gallagher Bassett Services, Inc. for your workplace injury.

Injured Worker

No Cost	STEP 1	Complete the information requested in the bottom portion below.
	STEP 2	Call First Script at 1-866-445-7344 to enroll, and receive your required Member ID.
	STEP 3	Present this form to your pharmacist along with the prescriptions for your work-related injury.
No Delay	First Script is available at over 68,000 pharmacies nationwide. To locate a nearby pharmacy, please call First Script Customer Service at 1-866-445-7344.	
Feel Better Faster	Please note that First Script is valid only for medications prescribed to treat your compensable work-related injury. You or your group health insurer, are financially responsible for any other prescriptions. The workers' compensation carrier will determine the compensability of the claim.	

Pharmacy Instructions

The injured worker's employer participates in First Script, a pharmacy benefit program administered by ESI/Medco. Call the First Script Help Desk, 24 hours a day, 7 days a week, at 1-866-445-7344. If the Member ID number is not listed on this form, please provide the claimant information indicated below to receive the Member ID #. Please note the ID number on the form and return to injured worker. First Script claims are submitted electronically and electronic approval of the claim will be returned.

Pharmacy: You will not be required to submit any paperwork for this claim and payment is guaranteed for all electronically accepted claims.

FIRST SCRIPT®

Pharmacy: At the request of the workers' compensation carrier for this customer, please use the following information to process all workers' compensation prescriptions online.

Name: _____

SSN (Last 4 digits): XXX-XX-_____

Date of birth: ____/____/____

State where injury occurred: _____

Date of injury: ____/____/____

Member ID: _____

(Member ID # is generated at time of enrollment)

(Above information to be completed by injured worker or supervisor)

RX PROGRAM ADMINISTERED BY: ESI/Medco

GROUP NUMBER: FSNCVTY

BIN NUMBER: 610014

Client #: 009006

Employer Name: **State of Nebraska**

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Appendix C

Claim Number:

GALLAGHER BASSETT SERVICES, INC.
AUTHORIZATION FOR RELEASE OF INFORMATION
(HIPAA COMPLIANT)

Patient Information:

	BD:		SS#	

(Print Name of Patient)

Information to be released from: _____
Name of Designated Facility or Provider

_____
Address

_____ _____
City, State, Zip Code Phone Number

Information to be sent to:

GALLAGHER BASSETT SERVICES, INC.
ATTN: (assigned claims handler)
Name of Designated Recipient

10050 Regency Circle, Suite 300
Address

Omaha, NE 68114 402.763.1485
City, State, Zip Code Phone Number

Information to be released:

- ☐ The most recent 2 years of pertinent information (chart notes, labs, X-rays and special tests)
- ☒ All medical records
- ☐ Specific information (Please specify)

Purpose for which disclosure is being made: Processing of an insurance claim.
Date of Loss:

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Claim Number: [redacted]

Patient Authorization:
I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

*** EXCLUDE the following information from the records released (please initial):**

____	Drug/Alcohol abuse /treatment & diagnosis	____	Sexually Transmitted Disease
____	HIV/AIDS diagnosis/treatment/ testing	____	Mental Illness or psychiatric diagnosis/treatment

My Rights:
I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

SIGNATURE: _____ DATE: [redacted] _____
(Patient, Guardian*, or Authorized Representative*)
[*Please provide documents to prove authority to sign on behalf of the patient]

SHALL BE VALID FOR ONE YEAR FROM THE ABOVE DATE
PHOTOCOPY VALID AS ORIGINAL